

		FOR OFF USE					

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**2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)**

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0038307</u> Facility Name: <u>HERITAGE MANOR-ELGIN</u> Address: <u>RAYMOND & WATCH</u> <u>ELGIN</u> <u>61701</u> <div style="display: flex; justify-content: space-around; width: 100%;"> Number City Zip Code </div> County: <u>KANE</u> Telephone Number: <u>(847) 697-6636</u> Fax # <u>()</u> IDPA ID Number: <u>370909086011</u> Date of Initial License for Current Owners: <u>03/28/89</u> Type of Ownership: <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code <u> </u> </div> <div> <input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other <u> </u> </div> <div> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other <u> </u> </div> </div>	
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In the event there are further questions about this report, please contact:
Name CRAIG L. ATER **Telephone Number:** (309) 823-7135

DPA 3745 (N-4-99)

IL478-2471

Print Preview

Facility Name & ID Number HERITAGE MANOR-ELGIN# 0038307 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>94</u>	Skilled (SNF)	<u>94</u>	<u>34,310</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>0</u>	Intermediate (ICF)	<u>0</u>	<u>0</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>94</u>	TOTALS	<u>94</u>	<u>34,310</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>15,708</u>	<u>8,766</u>	<u>1,629</u>	<u>26,103</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC	<u>0</u>	<u>0</u>	<u>0</u>		12
13	DD 16 OR LESS					13
14	TOTALS	<u>15,708</u>	<u>8,766</u>	<u>1,629</u>	<u>26,103</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4 76.08%)D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
none

F. Does the facility maintain a daily midnight census? _____

G. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?
YES ☐ NO ☒H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒I. On what date did you start providing long term care at this location?
Date started 1989J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 1989 NO ☐K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number
of beds certified _____ and days of care provided 1,629Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

MODIFIED
ACCRUAL ☐ CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: _____ Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

Print Preview

	G/L	RECAP CENSUS	DIFF
PP	8998	8998	0
IPA	15740	15740	0
medicare	1629	1629	0
	26367	26367	
IPA BEDHOLDS	32		
PP BEDHOLDS	0		
PP CONVERS	232		

STATE OF ILLINOIS

Page 3

Facility Name & ID Number HERITAGE MANOR-ELGIN

0038307

Report Period Beginning: 01/01/01

Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	178,185	12,648	0	190,833		190,833	2,906	193,739		1
2	Food Purchase		125,800		125,800		125,800	(629)	125,171		2
3	Housekeeping	129,594	19,314		148,908		148,908	0	148,908		3
4	Laundry	26,573	17,750		44,323		44,323	0	44,323		4
5	Heat and Other Utilities			114,253	114,253		114,253	1,183	115,436		5
6	Maintenance	56,777	35,611	27,870	120,258		120,258	9,320	129,578		6
7	Other (specify):*							0			7
8	TOTAL General Services	391,129	211,123	142,123	744,375		744,375	12,780	757,155		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000	0	6,000		9
10	Nursing and Medical Records	1,268,604	67,983	6,594	1,343,181		1,343,181	0	1,343,181		10
10a	Therapy		122,425	124,123	246,548	(255,813)	(9,265)	123,148	113,883		10a
11	Activities	65,717	2,470	0	68,187		68,187	0	68,187		11
12	Social Services	31,948	0	2,120	34,068		34,068	0	34,068		12
13	Nurse Aide Training	0	0					1,737	1,737		13
14	Program Transportation							0			14
15	Other (specify):*							0			15
16		1,366,269	192,878	138,837	1,697,984	(255,813)	1,442,171	124,885	1,567,056		16
	C. General Administration										
17	Administrative	60,320			60,320		60,320	25,755	86,075		17
18	Directors Fees							4,033	4,033		18
19	Professional Services			214,323	214,323		214,323	(197,318)	17,005		19
20	Dues, Fees, Subscriptions & Promotions			74,746	74,746	(51,465)	23,281	(7,103)	16,178		20
21	Clerical & General Office Expense	139,061	16,523	18,700	174,284		174,284	139,845	314,129		21
22	Employee Benefits & Payroll Taxes			220,740	220,740		220,740	19,850	240,590		22
23	Inservice Training & Education			941	941		941	762	1,703		23
24	Travel and Seminar			8,466	8,466		8,466	(6,467)	1,999		24
25	Other Admin. Staff Transportation							0			25
26	Insurance-Prop.Liab.Malpractice			21,668	21,668		21,668	1,428	23,096		26
27	Other (specify):*			51,911	51,911		51,911	(51,773)	138		27
28	TOTAL General Administration	199,381	16,523	611,495	827,399	(51,465)	775,934	(70,988)	704,946		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,956,779	420,524	892,455	3,269,758	(307,278)	2,962,480	66,677	3,029,157		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Print Preview

Facility Name & ID Number **HERITAGE MANOR-ELGIN**# **0038307**Report Period Beginning: **01/01/01** Ending: **12/31/01****V. COST CENTER EXPENSES (continued)**

	Capital Expense	Cost Per General Ledger				Reclass- ification	Reclassified Total	Adjust- ments	Adjusted Total	FOR OHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			93,409	93,409		93,409	8,171	101,580		30
31	Amortization of Pre-Op. & Org.							0			31
32	Interest			83,497	83,497		83,497	(581)	82,916		32
33	Real Estate Taxes			42,058	42,058		42,058	0	42,058		33
34	Rent-Facility & Grounds							6,677	6,677		34
35	Rent-Equipment & Vehicles			1,742	1,742		1,742	13,645	15,387		35
36	Other (specify):*							0			36
37	TOTAL Ownership			220,706	220,706		220,706	27,912	248,618		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation							0			38
39	Ancillary Service Centers					255,813	255,813	0	255,813		39
40	Barber and Beauty Shops	0	0	0				0			40
41	Coffee and Gift Shops							0			41
42	Provider Participation Fee					51,465	51,465	0	51,465		42
43	Other (specify):*							0			43
44	TOTAL Special Cost Centers					307,278	307,278		307,278		44
45	GRAND TOTAL COST										
	(sum of lines 29, 37 & 44)	1,956,779	420,524	1,113,161	3,490,464	0	3,490,464	94,589	3,585,053		45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Print Preview

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

STATE OF ILLINOIS

Page 5

Facility Name & ID Number **HERITAGE MANOR-ELGIN**

0038307

Report Period Beginning: **01/01/01**

Ending: **12/31/01**

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1 Amount	2 Refer- ence	3 OHF USE ONLY	
	NON-ALLOWABLE EXPENSES				
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Program:				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(300)	35		5
6	Rented Facility Space	0	34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	1,906	30		9
10	Interest and Other Investment Income	(501)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(629)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions	0	33		15
16	Personal Expenses (Including Transportation)		24		16
17	Non-Care Related Fees	(451)	20		17
18	Fines and Penalties				18
19	Entertainment	(11,881)	24		19
20	Contributions	0	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(2,238)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(51,773)	27		24
25	Fund Raising, Advertising and Promotional	(10,453)	20		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees	0	23		27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (76,320)		\$	30

OHF USE ONLY

48		49		50		51		52	
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B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below. (See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	170,909		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 170,909		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ 94,589		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference
38	Medically Necessary Transport			\$	38
39					39
40	Gift and Coffee Shops				40
41	Barber and Beauty Shops				41
42	Laboratory and Radiology				42
43	Prescription Drugs				43
44	Exceptional Care Program				44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

Print Preview

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.

IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Summary A

Facility Name & ID Numb HERITAGE MANOR-ELGIN

0038307 Report Period Beginning:

01/01/01

Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary
A

Operating Expenses		PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
A. General Services														
1	Dietary	0	0	2,906	0	0	0	0	0	0	0	0	2,906	1
2	Food Purchase	(629)	0	0	0	0	0	0	0	0	0	0	(629)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,183	0	0	0	0	0	0	0	0	1,183	5
6	Maintenance	0	0	9,320	0	0	0	0	0	0	0	0	9,320	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(629)	0	13,409	0	0	0	0	0	0	0	0	12,780	8
B. Health Care and Programs														
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	(14,101)	0	0	137,249	0	0	0	0	0	0	123,148	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	1,737	0	0	0	0	0	0	0	0	1,737	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Program	0	(14,101)	1,737	0	137,249	0	0	0	0	0	0	124,885	16
C. General Administration														
17	Administrative	0	0	25,755	0	0	0	0	0	0	0	0	25,755	17
18	Directors Fees	0	0	4,033	0	0	0	0	0	0	0	0	4,033	18
19	Professional Services	(2,238)	0	9,890	0	(204,970)	0	0	0	0	0	0	(197,318)	19
20	Fees, Subscriptions & Promotions	(10,904)	0	3,801	0	0	0	0	0	0	0	0	(7,103)	20
21	Clerical & General Office Expenses	0	0	139,845	0	0	0	0	0	0	0	0	139,845	21
22	Employee Benefits & Payroll Taxes	0	0	19,850	0	0	0	0	0	0	0	0	19,850	22
23	Inservice Training & Education	0	0	762	0	0	0	0	0	0	0	0	762	23
24	Travel and Seminar	(11,881)	0	5,414	0	0	0	0	0	0	0	0	(6,467)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,428	0	0	0	0	0	0	0	0	1,428	26
27	Other (specify):*	(51,773)	0	0	0	0	0	0	0	0	0	0	(51,773)	27
28	TOTAL General Administration	(76,796)	0	210,778	0	(204,970)	0	0	0	0	0	0	(70,988)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(77,425)	(14,101)	225,924	0	(67,721)	0	0	0	0	0	0	66,677	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

**SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.**

STATE OF ILLINOIS

Summary B

Facility Name & ID Number: HERITAGE MANOR-ELGIN

0038307

Report Period Beginning:

01/01/01

Ending:

12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary
B

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	1,906	0	0	6,265	0	0	0	0	0	0	0	8,171	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(501)	0	0	(80)	0	0	0	0	0	0	0	(581)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	6,677	0	0	0	0	0	0	0	6,677	34
35	Rent-Equipment & Vehicles	(300)	0	0	13,945	0	0	0	0	0	0	0	13,645	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	1,105	0	0	26,807	0	0	0	0	0	0	0	27,912	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(76,320)	(14,101)	225,924	26,807	(67,721)	0	0	0	0	0	0	94,589	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number HERITAGE MANOR-ELGIN STATE OF ILLINOIS # 0038307 Report Period Beginn 01/01/01 Ending: 12/31/01 Page 6A

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1 Dietary	\$	Heritage Enterprises, Inc.	100.00%	\$ 2,906	\$ 2,906
16	V	2 Food Purchase				0	
17	V	3 Housekeeping				0	
18	V	4 Laundry				0	
19	V	5 Heat & Other Utilities				1,183	1,183
20	V	6 Maintenance				9,320	9,320
21	V	7 Other				0	
22	V	9 Medical Director				0	
23	V	10 Nursing & Medical Records				0	
24	V	11 Activities				0	
25	V	12 Social Service				0	
26	V	13 Nurse Aide Training				1,737	1,737
27	V	14 Program Transportation				0	
28	V	15 Other				0	
29	V	17 Administrative				25,755	25,755
30	V	18 Directors Fees				4,033	4,033
31	V	19 Professional Services				9,890	9,890
32	V	20 Fees, Subscription, Promotion				3,801	3,801
33	V	21 Clerical & General Office Expenses				139,845	139,845
34	V	22 Employee Benefits & Payroll Taxes				19,850	19,850
35	V	23 Inservice Training & Education				762	762
36	V	24 Travel and Seminar				5,414	5,414
37	V	25 Other Admin, Staff Transportation				0	
38	V	26 Insurance-Prop.Liab.Malpract				1,428	1,428
39	Total		\$			\$ 225,924	\$ * 225,924

Sum_6A

2906

1183

9320

1737

25755

4033

9890

3801

139845

19850

762

5414

1428

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Page 6B

Facility Name & ID Number HERITAGE MANOR-ELGIN # 0038307 Report Period Beginn 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V 27	Other	\$	Heritage Enterprises, Inc.	100.00%	\$ 0	\$
16	V 30	Depreciation				6,265	6,265
17	V 31	Amortization of Pre-Op & Org				0	
18	V 32	Interest				(80)	(80)
19	V 33	Real Estate Taxes				0	
20	V 34	Rent-Facility & Grounds				6,677	6,677
21	V 35	Rent-Equipment & Vehicles				13,945	13,945
22	V 36	Other				0	
23	V 38	Medically Nec Transportation				0	
24	V 39	Ancillary Service Centers				0	
25	V 40	Barber and Beauty Shops				0	
26	V 41	Coffee and Gift Shops				0	
27	V 42	Other				0	
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 26,807	\$ * 26,807

Sum_6B

6265

-80

6677

13945

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Page 6C

Facility Name & ID Number HERITAGE MANOR-ELGIN # 0038307 Report Period Beginn 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	19 Adjustment for Related Organization	\$ 204,970	Heritage Enterprises, Inc.		\$	\$ (204,970)
16	V						
17	V	10a Adjustment for Related Organization	118,379	Green Tree Pharmacy	100.00%	255,628	137,249
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 323,349			\$ 255,628	\$ * (67,721)

Sum_6C

-204970

137249

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V		\$			\$	\$
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$	\$ *

Sum_6D

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Page 6E

Facility Name & ID Number HERITAGE MANOR-ELGIN # 0038307 Report Period Beginn 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V		\$			\$	\$
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$	\$ *

Sum_6E

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Page 6F

Facility Name & ID Number HERITAGE MANOR-ELGIN # 0038307 Report Period Beginn 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V		\$			\$	\$
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$	\$ *

Sum_6F

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Page 6G

Facility Name & ID Number HERITAGE MANOR-ELGIN # 0038307 Report Period Beginn 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V		\$			\$	\$
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$	\$ *

Sum_6G

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
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STATE OF ILLINOIS

Page 6H

Facility Name & ID Number HERITAGE MANOR-ELGIN # 0038307 Report Period Beginn 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V		\$			\$	\$
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$	\$ *

Sum_6H

* Total must agree with the amount recorded on line 34 of Schedule VI.

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1. Enter the information on pages 5 and 5A.
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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
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SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Page 6I

Facility Name & ID Number HERITAGE MANOR-ELGIN

0038307

Report Period Beginnin 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V		\$			\$	\$
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ *	

Sum_6I

* Total must agree with the amount recorded on line 34 of Schedule VI.

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1. Enter the information on pages 5 and 5A.
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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
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VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Compensation Received From Other Nursing Homes*	Average Hours Per Work	Compensation Included in Costs for this Reporting Period**	Schedule V. Line & Column Reference		
							Week Devoted to this Facility and % of Total Work Week				
	Name	Title	Function	Ownership Interest		Hours	Percent	Description	Amount		
1	Bill Froelich	Chairman of Board	Management	0.26	28,743	10	0.20	Directors Fees	\$ 1,011	line 18, col 7	1
2	Tom Jefferson	Asst Secretary/Tre	Management	0.10	28,743	10	0.20	Directors Fees	1,010	line 18, col 7	2
3	Craig Hart	Secretary/Treasure	Management	0.20	28,743	10	0.20	Directors Fees	1,010	line 18, col 7	3
	Joe Warner	President	Management	0.03	10,265	48	0.95	Directors Fees	361	line 18, col 7	
4	Bill Froelich	Chairman of Board	Management	0.26	99,156	10	0.20	Salary	3,482	line 17, col 7	4
5	Tom Jefferson	Asst Secretary/Tre	Management	0.10	97,545	10	0.20	Salary	3,426	line 17, col 7	5
6	Craig Hart	Secretary/Treasure	Management	0.20	82,417	10	0.20	Salary	2,895	line 17, col 7	6
7	Joe Warner	President	Management	0.03	110,973	48	0.95	Salary	3,898	line 17, col 7	7
8	Bob Dickson	Executive Vice Pre	Management	0.01	60,398	50	1.00	Salary	2,122	line 17, col 7	8
9	Cheryl Lowney	Executive Vice Pre	Management	0.00	50,742	50	1.00	Salary	1,782	line 17, col 7	9
10	Steve Wannemacher	Executive Vice Pre	Management	0.00	49,114	50	1.00	Salary	1,725	line 17, col 7	10
11	Connie Hoselton	Sr Vice President	Management	0.00	33,744	40	1.00	Salary	1,185	line 17, col 7	11
12	Craig Ater	Sr Vice President	Management	0.00	32,121	50	1.00	Salary	1,128	line 17, col 7	12
13								TOTAL	\$ 25,035		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REI

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees)
**FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME
 ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION**

Print Preview

| the name(s)
PORTS.

Facility Name & ID Number **HERITAGE MANOR-ELGIN**# **0038307** Report Period Beginning: **01/01/01**Ending: **12/31/01**

VIII. ALLOCATION OF INDIRECT COSTS

Show Pgs 8A thru 8D

Show Pgs 8E thru 8I

Hide Pgs 8A thru 8I

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Heritage EnterprisesStreet Address 115 W. JeffersonCity / State / Zip Code Bloomington, ILPhone Number ()Fax Number ()

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	BEDS	2,328	23	\$ 71,961	\$ 71,961	94	\$ 2,906	1
2	2	Food Purchase	BEDS	2,328	23	0	0	94	0	2
3	3	Housekeeping	BEDS	2,328	23	0	0	94	0	3
4	4	Laundry	BEDS	2,328	23	0	0	94	0	4
5	5	Heat & Other Utilities	BEDS	2,328	23	29,301	0	94	1,183	5
6	6	Maintenance	BEDS	2,328	23	230,824	54,124	94	9,320	6
7	7	Other	BEDS	2,328	23	0	0	94	0	7
8	9	Medical Director	BEDS	2,328	23	0	0	94	0	8
9	10	Nursing & Medical Records	BEDS	2,328	23	0	0	94	0	9
10	11	Activities	BEDS	2,328	23	0	0	94	0	10
11	12	Social Service	BEDS	2,328	23	0	0	94	0	11
12	13	Nurse Aide Training	BEDS	2,328	23	43,025	0	94	1,737	12
13	14	Program Transportation	BEDS	2,328	23	0	0	94	0	13
14	15	Other	BEDS	2,328	23	0	0	94	0	14
15	17	Administrative	BEDS	2,328	23	637,854	637,854	94	25,755	15
16	18	Directors Fees	BEDS	2,328	23	99,885	0	94	4,033	16
17	19	Professional Services	BEDS	2,328	23	244,928	0	94	9,890	17
18	20	Fees, Subscription, Promotion	BEDS	2,328	23	94,145	0	94	3,801	18
19	21	Clerical & General Office Exp	BEDS	2,328	23	3,463,403	3,114,857	94	139,845	19
20	22	Employee Benefits & Payroll	BEDS	2,328	23	491,614	0	94	19,850	20
21	23	Inservice Training & Education	BEDS	2,328	23	18,866	0	94	762	21
22	24	Travel and Seminar	BEDS	2,328	23	134,093	0	94	5,414	22
23	25	Other Admin. Staff Transport	BEDS	2,328	23	0	0	94	0	23
24	26	Insurance-Prop.Liab.Malprac	BEDS	2,328	23	35,366	0	94	1,428	24
25	TOTALS					\$ 5,595,265	\$ 3,878,796		\$ 225,924	25

Print Preview

Facility Name & ID Number HERITAGE MANOR-ELGIN# 0038307 Report Period Beginning: 01/01/01Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	27	Other	BEDS	2,328	23	\$ 0	\$ 0	94	\$ 0	1
2	30	Depreciation	BEDS	2,328	23	155,150	0	94	6,265	2
3	31	Amortization of Pre-Op & Or	BEDS	2,328	23	0	0	94	0	3
4	32	Interest	BEDS	2,328	23	(1,990)	0	94	(80)	4
5	33	Real Estate Taxes	BEDS	2,328	23	0	0	94	0	5
6	34	Rent-Facility & Grounds	BEDS	2,328	23	165,362	0	94	6,677	6
7	35	Rent-Equipment & Vehicles	BEDS	2,328	23	345,363	0	94	13,945	7
8	36	Other	BEDS	2,328	23	0	0	94	0	8
9	38	Medically Nec Transportation	BEDS	2,328	23	0	0	94	0	9
10	39	Ancillary Service Centers	BEDS	2,328	23	0	0	94	0	10
11	40	Barber and Beauty Shops	BEDS	2,328	23	0	0	94	0	11
12	41	Coffee and Gift Shops	BEDS	2,328	23	0	0	94	0	12
13	42	Other	BEDS	2,328	23	0	0	94	0	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 663,885	\$		\$ 26,807	25

Facility Name & ID Number HERITAGE MANOR-ELGIN# 0038307 Report Period Beginning: 01/01/01Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number HERITAGE MANOR-ELGIN# 0038307 Report Period Beginning: 01/01/01Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number HERITAGE MANOR-ELGIN# 0038307 Report Period Beginning: 01/01/01Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number HERITAGE MANOR-ELGIN# 0038307 Report Period Beginning: 01/01/01Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	LaSalle National Bank		XX	Mortgage	2783+INT	01/20/01	\$ 676,381	\$ 804,450	01/15/06	variable	\$ 79,538	1	
2	LaSalle National Bank Amortizati		XX	Mortgage							3,959	2	
3	Central Office Allocation		XX	Interest Income							(80)	3	
4												4	
5												5	
	Working Capital												
6												6	
7											0	7	
8												8	
9	TOTAL Facility Related						\$ 676,381	\$ 804,450			\$ 83,417	9	
	B. Non-Facility Related*												
10	Interest Income										501	10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ 501	14	
15	TOTALS (line 9+line14)						\$ 676,381	\$ 804,450			\$ 82,916	15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

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Facility Name & ID Number **HERITAGE MANOR-ELGIN**# **0038307** Report Period Beginning: **01/01/01** Ending: **12/31/01****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 2000 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	42,067	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	41,036	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(1,031)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	43,089	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6			\$	42,058	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1996		8
	1997		9
	1998		10
	1999		11
	2000		12

FOR OFF USE ONLY	
13	FROM R. E. TAX STATEMENT FOR 2000 \$ 13
14	PLUS APPEAL COST FROM LINE 5 \$ 14
15	LESS REFUND FROM LINE 6 \$ 15
16	AMOUNT TO USE FOR RATE CALCULATIC \$ 16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

Print Preview

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be

To Print this page only

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2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME HERITAGE MANOR-ELGIN COUNTY KANE

FACILITY IDPH LICENSE NUMBI 0038307

CONTACT PERSON REGARDING THIS REP(CRAIG L. ATER

TELEPHONE (309) 823-7135 FAX # ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>0624201002</u>	<u>HERITAGE MANOR-ELGIN</u>	\$ <u>992</u>	\$ <u>992</u>
2. <u>0624201003</u>	<u>HERITAGE MANOR-ELGIN</u>	\$ <u>39,292</u>	\$ <u>39,292</u>
3. <u>0624201004</u>		\$ <u>752</u>	\$
4. <u></u>		\$	\$
5. <u></u>		\$	\$
6. <u></u>		\$	\$
7. <u></u>		\$	\$
8. <u></u>		\$	\$
9. <u></u>		\$	\$
10. <u></u>		\$	\$
TOTALS		\$ <u>41,036</u>	\$ <u>40,284</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES xx NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 33,800 B. General Construction Type: Exterior Frame Number of Stories

C. Does the Operating Entity? ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☐ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☐ NO

If so, please complete the following:

1. Total Amount Incurred: _____ **2. Number of Years Over Which it is Being Amortized:** _____

3. Current Period Amortization: _____ **4. Dates Incurred:** _____

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4
	Use	Square Feet	Year Acquired	Cost
1	Nursing Home		1989	\$ 70,450
2	Nursing Home			
3	TOTALS			\$ 70,450

Print Preview

Facility Name & ID Number HERITAGE MANOR-ELGIN

0038307

Report Period Beginning:

01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	94				\$ 720,000	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	1989 Improvements			1989	180,739						9
10	1990 Improvements			1990	658,346						10
11	1990 Improvements			1990	4,320						11
12	1991 Improvements			1991	52,989						12
13	1992 Improvements			1992	6,777						13
14	1993 Improvements			1993	54,564						14
15	1994 Improvements			1994	81,347						15
16	1995 Improvements			1995	146,394						16
17	Remodel Resident Day Room/Nurses Station			1996	23,749						17
18	Interior Rehab			1997	751						18
19	Electric Water Heater			1997	3,965						19
20	Booster Heater			1997	1,622						20
21	Water Heater and Storage Tank			1998	6,485						21
22											22
23	Water Heater			1999	4,750						23
24	Code Alert System			1999	1,570						24
25	Resident Room Remodel--Material and Labor			1999	2,571						25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34	C/O Allocation							6,265	6,265		34
35	Book Depreciation					62,026		62,755	729	624,704	35
36					1,950,939						36

* Total beds on this schedule must agree with page 2.

See page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

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0 Page 12C
0 Page 12D
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0 Page 12F
0 Page 12G
0 Page 12H
0 Page 12I

XI. OWNERSHIP COSTS (continued)
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 South Wing Remodel -- Labor / Materials	2000	14,334						37
38 Door	2000	1,535						38
39 Dry Chemical Extinguisher	2000	1,746						39
40								40
41 Water Heater	2001	4,935						41
42 Valve thermometer	2001	4,520						42
43 A/C Unit	2001	3,319						43
44 Hallway Carpet and Tile Material and Labor	2001	28,843						44
45 Wallpaper	2001	2,390						45
46 Nurse Call System	2001	21,612						46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 83,234	\$ 62,026		\$ 69,020	\$ 6,994	\$ 624,704	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12A, Carried Forward		\$ 83,234	\$ 0		\$ 0	\$	\$ 624,704	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 83,234	\$ 0		\$ 0	\$ 0	\$ 624,704	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Facility Name & ID Numbe HERITAGE MANOR-ELGIN

0038307

Report Period Beginning:

01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12B, Carried Forward		\$ 83,234	\$ 0		\$ 0	\$	\$ 624,704	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
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26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 83,234	\$ 0		\$ 0	\$ 0	\$ 624,704	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Facility Name & ID Numbe HERITAGE MANOR-ELGIN

0038307

Report Period Beginning:

01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12C, Carried Forward		\$ 83,234	\$ 0		\$ 0	\$	\$ 624,704	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
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23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 83,234	\$ 0		\$ 0	\$ 0	\$ 624,704	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

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1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12D, Carried Forward		\$ 83,234	\$ 0		\$ 0	\$	\$ 624,704	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
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27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 83,234	\$ 0		\$ 0	\$ 0	\$ 624,704	34

**Improvement type must be detailed in order for the cost report to be considered complete.

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12E, Carried Forward		\$ 83,234	\$ 0		\$ 0	\$	\$ 624,704	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
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25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 83,234	\$ 0		\$ 0	\$ 0	\$ 624,704	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number **HERITAGE MANOR-ELGIN**# **0038307**Report Period Beginning: **01/01/01** Ending: **12/31/01****XI. OWNERSHIP COSTS (continued)****C. Equipment Depreciation-Excluding Transportation. (See instructions.)**

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Componer Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 385,015	\$ 31,383	\$ 32,560	\$ 1,177		\$ 294,203	71
72	Current Year Purchases	22,963						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 407,978	\$ 31,383	\$ 32,560	\$ 1,177		\$ 294,203	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,512,601	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 93,409	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 101,580	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 8,171	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 918,907	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

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XII. RENTAL COSTS**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34. _____

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.9. Option to Buy: ☐ YES ☐ NO Terms: _____ ***B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO16. Rental Amount for movable equipm: \$ 15,387 Description: Copier, Cell Phone and Central Office Allocation

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2001 \$ _____13. /2002 \$ _____14. /2003 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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Facility Name & ID Number HERITAGE MANOR-ELGIN # 0038307 Report Period Beginning: 01/01/01 Ending: 12/31/01**XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)****A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)**

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---	---	--

B. EXPENSES**ALLOCATION OF COSTS (d)**

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		0		
3	Classroom Wages (a)		0		
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)		0		
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

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XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
					1	Licensed Occupational Therapist	10a/3	hrs	\$		
2	Licensed Speech and Language Development Therapist	10a/3	hrs			1,959				1,959	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	10a/3	hrs			66,462	3,930			70,392	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	39/3	# of prescripts				255,743			255,743	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify):	39/3				70				70	13
14	TOTAL			\$		\$ 110,022	\$ 259,673		\$	369,695	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

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STATE OF ILLINOIS

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Facility Name & ID Number HERITAGE MANOR-ELGIN

0038307

Report Period Beginning: 01/01/01

Ending:

12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/01

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 38,468	\$	1
2	Cash-Patient Deposits	20,038		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	451,900		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	19,241		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	232,732		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 762,379	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	80,000		13
14	Buildings, at Historical Cost	2,029,851		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	407,978		16
17	Accumulated Depreciation (book methods)	(916,074)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	17,637		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,619,392	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,381,771	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 103,048	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	20,038		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	192,215		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,703		31
32	Accrued Real Estate Taxes(Sch.IX-B)	43,089		32
33	Accrued Interest Payable	2,782		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36		0		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 366,875	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	804,450		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 804,450	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,171,325	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,210,446	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,381,771	\$	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,314,966	1
2	Restatements (describe):		2
3	audit Adjustment	0	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,314,966	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(104,520)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (104,520)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,210,446	24 *

* This must agree with page 17, line 47.

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